MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-1383-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas I.S.D. Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.: 2002030079

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
01/16/03	**01/16/03**	**97750**	**$144.00**	**$144.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 09/19/03 states in part, "Our charge for Physical Performance Exam (97750) was partially paid. According to TWCC MFG reimbursement should be $43.00 per unit. Our charge was for 8 units, payment should have been for $344.00 and only $200.00 was paid. We attempted to appeal this partial payment via certified mail; however, the carrier never responded to our request".

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not respond to the initial request for MDR or the 14-day letter, which serves as a notice for the carrier to submit additional information. The notice was signed on January 4, 2005 and the 14 day timeframe has expired.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97750 (8 units) for date of service 01/16/03. The Requestor billed $344.00 for 8 units of a PPE; the insurance carrier paid $200.00 and used PEC "F – Reduction according to Fee Guideline. Charge exceeds the scheduled maximum allowance per the Medical Fee Guideline". Per the 1996 Medical Fee Guideline, Medicine Ground Rule, CPT code descriptor and Rule 133.304(b) additional reimbursement in the amount of $144.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/16/2003	97750	$144.00	$144.00				
				Total Left Column:			$144.00
				Total Amount Due:			$144.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $144.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	01-28-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____